House Appropriations Subcommittee on Foreign Operations, Export Financing and Related Programs Holds Hearing on Fiscal 2007 Appropriations: Foreign Operations

KOLBE:

We don't have a gavel this morning but that's all right. We'll survive without it here.

The Subcommittee on Foreign Operations will come to order here.
And I'd like to welcome our guest this morning, Dr. Mark Dybul, who is the deputy director of the presidential initiative on AIDS.

We want to welcome you here this morning to discuss with us the budget request for global HIV/AIDS and tuberculosis prevention programs in the fiscal year 2007 budget.

We approach this hearing with over two years of experience that we can build on. And I hope during the course of this hearing, we'll hear more about the initiative's progress and on plans during the coming year.

The president has requested $2.894 billion for the Global HIV Initiative account for fiscal year 2007, over $900 million above the fiscal year 2006 level.

For HIV/AIDS and T.B. overall, the budget recommends $4.031 billion and that's $743 million over the fiscal year 2006 appropriated level. That happens to be an increase of about 23 percent.

So you can see these are pretty dramatic increases and particularly when you look at other parts of the budget, which are not increased at all, or in many cases of domestic discretionary spending, they're actually requested below last year's level.

The Global HIV/AIDS Initiative continues to receive very broad bipartisan support in this subcommittee, in the full committee and the Congress as a whole.

In addition, your written testimony -- excuse me one moment. I've lost page two.

Here we go. I was working on this last night and I think I left it out there. I have the others there.

In addition, your written testimony notes the fiscal year 2007 is a critical year for ensuring success in meeting the program's objectives.

As you well know, though, budget resources are scarce. Difficult decisions will need to be made if we are to successfully meld both administration and congressional priorities and maintain the necessary fiscal constraint.

For many, the most visible indicator of the success of the PEPFAR program is the number of people that are receiving treatment.

You report in your fiscal year 2006 operational plan that the funding provided for the emergency plan will support care and services for 4,300,000 individuals infected and affected by HIV/AIDS, and will support the ARV, or anti-retroviral therapy, for at least 860,000 people.

To put this in context, just before the start of the initiative at the end of 2002, only 50,000 people in all of sub-Saharan Africa were receiving AIDS drugs.

Treatment, however, is one of the goals that we've got.

Treatment itself will not stop the spread of AIDS. Until a cure is found, only preventing new infections can slow the disease's spread. In fact, the potential risk of widespread treatment is that it may actually speed the development of viral resistance to the drugs that we have available to us.

I understand from your second annual report to Congress that the initiative has supported community outreach activities to over 42,000,000 people to help prevent sexual transmission.

Of that total, your testimony notes that the U.S. Support and Prevention Services of 3 million mothers and that has resulted in what is estimated to be averting an estimated 47,000 infant infections. That's good news.

And I understand in addition to those countries that we've seen before like Uganda and Thailand, we're now seeing some good news in the decline and infection rates in countries like Zimbabwe and Kenya.

In spite of this, however, the total number of people living with HIV continues to rise.

The most recent statistics are that over 40 million people are infected worldwide, with nearly 5 million newly infected last year. Clearly, a lot of work remains to be done.

Dr. Dybul, I look forward to hearing your assessment of the success so far of what has become known as the ABC prevention approach -- abstinence, be faithful, use of condoms -- and particular as this relates to Kenya.

I'm interested in exploring the role and effectiveness of mass media campaigns in reducing this behavior and preventing the spread of HIV.

I'd also like to hear your thoughts on the lessons learned now that we are in the third year of the PEPFAR activities.

How has our experience to date shaped our plans for the future? What has worked? What has not worked?

The fiscal year 2007 budget request again recommends reducing the U.S. contribution to the Global Fund to $300 million. That's down $244 million from last year's level.

As I discussed with Ambassador Tobias last year, I consider the Global Fund to be an important part of the long-term fight against AIDS, tuberculosis and malaria. And congressional support for the fund has been strong, though it has been constructively, I think, critical.

I'm interested in hearing your views about the role and progress of the fund, whether contributions -- particularly whether contributions from non-U.S. donors are expected to be sufficient for the full release of the U.S. contribution in fiscal

year 2006. And if so, then why the cut in the request for the U.S. contribution?

Finally, this time last year, I pressed Ambassador Tobias on the importance of sharing information with the public. You did that and I commend you for it.

One of the initiative's strengths, I think, is its ability to track funding and report results. I know that puts a burden on the people, your country teams, for the reporting information, but I think it's absolutely essential.

I think that kind of transparency increases confidence in the programs, allows us to share the lessons that you gather and I think increases support -- maintains and even increases support here in Congress and among the general public.

Ultimately, Dr. Dybul, the initiative will be successful only if it stimulates and sustains prevention, treatment and care activities of local health officials. This is an area where cooperation and coordination is especially crucial, for developing these institutions and maintaining this capacity is going to take all the resources and ingenuity of the international community.

There are a lot of topics we're going to be discussing here this morning. I have a number of questions -- I don't know how many of them I'll be able to get to.

And I look forward to hearing your testimony, Dr. Dybul.

But first, let me turn to my ranking member, Ms. Lowey, for her opening statements.

Ms. Lowey?

LOWEY:

Thank you, Mr. Chairman.

And I want to join you in welcoming Dr. Dybul to our subcommittee.

We understand you're playing a key role in keeping the mission and path of the Office of Global AIDS Coordinator steady during this transition period and we appreciate your hard work.

The president's request of $4.032 billion for global AIDS, T.B. and malaria programs for FY 2007, $3.441 billion from the foreign operations bill, is an increase of nearly $750 million over the FY '06 level.

I want to make it clear we appreciate that, because I just came from the hearing across the hall and Labor, HHS -- they're cutting education. They're cutting everything else.

So I'm glad at least we can thank you for an increase.

It has clearly come a long way from FY 2000 when USAID's budget to these programs totaled just $177 million and U.S. government funding totaled $337 million.

This is good news for the estimated 471,000 people who have received U.S.-funded treatment and the 9.4 million people who have received counseling and testing services, as well as the 47,000 children who have avoided contracting HIV because of U.S.-funded activities to prevent mother-to-child transmission of the virus.

We are doing what we should be doing and on the grand scale that the pandemic requires, and I commend you and Ambassador Tobias for your efforts.

According to your annual report submitted last month, in fiscal year 2005 you spent approximately 28 percent of all focus country program funding on prevention, 26 percent on care, 46 percent on treatment. And this breakdown does represent your efforts to build toward compliance with congressional directives, setting aside 20 percent for prevention and 55 percent for treatment.

Now, as you may know, I've never been a fan of the percentage targets set forth in the U.S. Leadership Against AIDS Act of 2003.

I feel they were set arbitrarily based more on emotion and ideology than on knowledge of what works.

And I hope you can be frank with us today, Dr. Dybul, about how these targets fit into a science and evidence-based approach to combating the AIDS pandemic.

I have a few concerns I would like to touch upon right now and I hope we can follow up on these issues during the question period.

First and foremost, I'm deeply concerned that the way prevention funding is being divvied up is having negative effects on the flexibility of the United States programs around the world to deal with the specific needs pertaining to HIV/AIDS and individual missions.

In order to meet the 33 percent abstinence until marriage earmarked within prevention funds, the Office of the Global AIDS Coordinator has mandated the country teams, including in non-focus countries, spend half of their prevention funds on sexual transmission prevention with a full two-thirds of that going to abstinence and safer from (inaudible) or ABC activities.

I believe these strict targets fly in the face of OGAC's commitment to providing integrated prevention programs that are responsive to local epidemiology and cultural norms.

I understand and believe in the value of programs that delay the start of sexual activity. I want to make that very clear that I do believe that that's important. And limiting the number of partners is important.

But I have concerns about the effect of the 33-percent target and the way it is being implemented on our country programs.

AIDS is not only a public health issue; it is a development issue. And it must be treated in my judgment, as such. This means that OGAC cannot exist as an island

in our foreign assistance programs.

Insufficient nutrition hinders the ability of people under anti- retroviral treatment to absorb their medication and adhere to treatment regimens. We heard this everywhere.

Providing testing and treatment will only go so far if nutrition is inadequate, clean water is unavailable and those whose lives are saved have no educational and economic opportunity.

Prevention measures are only as successful as people's abilities to process and act on them.

When insufficient attention is paid to problems like widespread gender-based violence, prevalent child marriage, lack of women's property rights, prevention messages, focusing on choice and behavior change simply won't work.

I understand that OGAC has a mission given to it by the president and that mission includes a narrowly defined set of goals.

But our successes in combating AIDS will not be sustainable if they're funded at the expense of every other interlocking development intervention. And I hope you can address this today.

It is my understanding that we have made great strides in the last several years in increasing the availability and effectiveness and decreasing the price of anti-retrovirals and other AIDS therapies.

Our efforts and those of other donors concentrated in heavily- populated, severely-affected urban areas have been successful in getting treatment for more than 1 million people.

We cannot stop there, however.

We need to ensure that our efforts reach rural populations affected by AIDS, the people who could benefit from simple treatments if they weren't too sick or too hungry to walk miles to the nearest clinic.

We need to figure out how the donor community will work with host countries to ensure that those receiving treatment through U.S. Global Fund and other programs continue to receive that treatment as long as they need it.

We need to address human capacity constraints and brain drain in affected countries, which will hinder the development of health infrastructures sufficient to deal with the pandemic.

And in my judgment, we need to pay more attention to countries like India, Indonesia and the former Soviet Republic that are not on the list of PEPFAR focus counties but are severely affected nonetheless.

Dr. Dybul, I look forward to working with you to address these challenges and I welcome your remarks.

KOLBE:

Dr. Dybul, we look forward to hearing your testimony, and as you know, the full statement can be placed in the record so you may summarize it if you wish.

We'd like to have you do that.

DYBUL:

Thank you, Mr. Chairman, and thank you, Congresswoman Lowey and members of the subcommittee.

I will actually clip through a number of things, particularly since both of you were kind enough to cover a number of them.

We appreciate the opportunity to discuss President Bush's fiscal year 2007 budget request for his emergency plan for AIDS relief. And we would like to note how much we greatly appreciate the partnership between PEPFAR and this committee.

We would like to thank all the members of the subcommittee, and particularly you, Mr. Chairman, for your commitment to U.S. leadership in the fight against this tragic epidemic.

And it is thanks to the commitment of the Congress, this committee, and the rest of Congress, the president, and the American people.

The U.S. government is by far the largest contributor to the fight against HIV/AIDS. Based on UNAIDS estimates, in 2004, our government contributed more than all other governments combined and will continue to lead the global effort with the president's request this year.

As you mentioned, the president's request covers all bilateral programs in approximately 120 countries around the world, our research contributions and our contributions to important multilateral organizations, including the Global Fund.

In the brief time I have, I'd like to briefly touch on some aspects of the budget in particular as they relate to the bilateral program. And as you've noted, that includes a request for an increase of over $700 million.

As you noted, the first two years of the bilateral emergency plan programs, which are undertaken in partnership with host nations, have achieved extraordinary results, but I wanted to emphasize the partnership.

PEPFAR fundamentally supports a multisectoral effort in-country with the American people standing shoulder to shoulder with countries and communities as they fight against their epidemics.

But let me take a moment to summarize the results of this partnership but not repeating what you have stated.

The efforts on prevention have been extraordinary and have reached a number of people with ABC and also with prevention of mother-to-child activities.

I also would like to note that we supported 600 blood-safety service outlets, which is an important piece of prevention.

As we mentioned, PEPFAR supported life-extending treatment for 401,000 people in the focus countries and 470,000 overall.

I would like to point out that the number of children receiving support for therapy doubled from the last report and we expect that to increase as we go forward.

In addition, highlighting an important point Congresswoman Lowey mentioned, approximately 60 percent of those receiving therapy at the sites we supported are women and we are very focused on women's issues related to HIV/AIDS.

The emergency plan supported care for nearly 3 million orphans and vulnerable children, HIV-positive persons. And as noted, counseling and testing, which is an important gateway to prevention, care, and treatment, has been supported for 9.4 million.

I mention that again to note that 69 percent of those who we supported regarding counseling and testing were women.

Undergirding all of these accomplishments, as was noted, is a partnership with host nations so that we can ensure the responses are sustained over the long term and also that U.S. government currently is supporting country-owned programs, which is the only solution.

There can be no results without building local capacity.

So the U.S. government has worked hard to support local capacity, including nearly 850,000 trainings and retrainings for service providers over two years, laying the foundation for continued success.

These results reflect the unprecedented speed and effectiveness which funds have been utilized in the bilateral programs.

After the first 20 months of PEPFAR, over 94 percent of our funds were obligated and approximately 60 percent were outlaid, which I think is an extraordinary achievement and a remarkable comment on the dedication of the people in-country doing the work, as well as U.S. government personnel pushing those resources to save as many lives as quickly as possible.

Funding the president's request for 2007 allows us to continue this work and is essential if we are to meet the goals of the president and Congress: to support treatment for 2 million, to support prevention of 7 million infections, and to support care for 10 million.

I could briefly just discuss treatment.

An informal survey of U.S. government teams in six focus countries in 2005 revealed that current capacity, because we had put so much effort on building capacity, supported the availability of treatment for an additional 82,000 people. However, resources were not available through the bilateral programs.

For the coming year, based on this and other analyses, we estimate that across the 15 focus countries a reduction of only $100 million in the focus countries in 2007, which would include approximately $55 million for treatment, would lead to 39,000 fewer people receiving treatment.

Although we talk much about treatment prevention, as the chairman noted, it is the cornerstone of PEPFAR as we all strive to achieve a generation free from AIDS.

In prevention funding, constraints also greatly limit the ability of our partners through the bilateral program to meet urgent needs.

For example, as noted, our country teams have had to make very difficult choices among prevention programs, all of which are good programs, but necessary choices dictated in part by limitation of funding, as resources requested for focus country bilateral programs have been directed to other activities. Similar tradeoffs can be found among care programs.

Because capacity needs to be built today to achieve our goals, we cannot meet the 2008 goals without the resources requested for the bilateral programs in 2007.

And no increase in 2008 could make up the difference because of the need to build the capacity in 2007.

The Global Fund remains an important part of the emergency plan strategy, and U.S. government remains by far its largest single contributor of funds.

I would also say technical support -- the people that go and participate in Global Fund committees, serve and support the fund in the countries, is extraordinary and we've given specific guidance that, that is a part of what we do as a government -- support the Global Fund.

However, each country, including the United States, needs to find the right mix of bilateral and multilateral contributions to get the most immediate results in this emergency from its investment.

In light of the achievements, capacity and efficiency of U.S. bilateral programs, we believe the president's request strikes the right balance for fiscal year 2007. That may change in the future.

Mr. Chairman, I understand the difficult tradeoffs of this subcommittee and the difficult tradeoffs you have to meet in light of the wide range of international challenges our nation faces.

And I thank you for consideration of the president's request.

This subcommittee can be proud that through the president's emergency plan, the American people are partners with families, communities and nations that are

reclaiming their future.

Mr. Chairman, Ms. Lowey, I would be happy to address your questions.

KOLBE:

Thank you very much, Dr. Dybul.

Mark, we certainly appreciate your testimony here.

In lieu of the usual questioning going back and forth in the order of the people arrived in the committee room once we started here, let me begin with a question that deals with what we call the 2- 7-10 goals here.

You've said in your testimony, written testimony -- again, you said verbally here that you've determined that the president's requested level for the focus country is essential -- that's the word that's used -- if we are going to meet the goals the president and Congress has to support treatment of 2 million HIV-infected people, 7 million preventions of infection and 10 million people in care.

Are you saying that if Congress does not provide the full appropriation requested, we will not meet the five-year goals, even though we're just in considering the appropriation for year four?

DYBUL:

Yes, Mr. Chairman, we believe that is the case.

And it really has to do with something that's been discussed much over the last couple of years, which is scale-up -- and the reason we began with $2.4 billion as a request in 2004 and our $4 billion today, that you build capacity as you go.

And the capacity needs to be created in advance of services. You need to train the people, get the treatment and care clinics together, get the prevention community together so that they can expand their programs further.

And we have a scale-up not only in resources, but in results. For example, in treatment from '07 to '08, going from 1.3 million people to 2 million people. You can't do that by fiat. You need to build the capacity for that expansion.

And if that capacity isn't available in 2007, doubling the money in 2008 still won't get you there because it's not just money, it's making the money work on the ground and that requires capacity.

KOLBE:

Your 2-7-10 goals are not just PEPFAR's. It's Global Fund. It's everything.

So are you taking into account what the Global Fund is doing and other bilateral programs and our other bilateral programs?

DYBUL:

Yes, sir, we are.

And in fact, 400...

(CROSSTALK)

DYBUL:

Yes, that's correct.

And a lot of it has to do with just working through the money.

You know, 60 percent of the Global Fund resources go for HIV/AIDS, not 100 percent, so you immediately back our contribution down by 60 percent. Then figuring out the different percents that go for different activities. And when you get to that, the incremental increase, no matter what our contribution to the fund is, will not make up those numbers.

And we've done those calculations. We're happy to share them with you.

KOLBE:

Although, in theory, if we were to, say, not put the money into the PEPFAR's program and put more of it into the Global Fund, and they were focused on the same goals, you might still reach those goals through a different source of funding, is that not right?

DYBUL:

We would be happy to work with you on that, but we don't believe that's the case for a variety of reasons, including the fact that appropriately, the bilateral and Global Fund programs on the ground we are intermingling so that we're supporting each other so it's not as if every person is additive.

And we in our annual report explain how we have cross-over in terms of people we support. So increasing money to the fund will not necessarily, in the same way, incrementally increase the achievability of goals.

KOLBE:

Well, related to that then. You talk about the capacity in the focus countries in 2005 to treat an additional 82,000, I think is the figure that you use.

Are you also, then, in that excluding funds that might be available from non-U.S. donors, in other words, other Global Fund sources?

DYBUL:

We are not excluding them at all.

And in fact, we work hard in-country to identify additional resources that could support the capacity that's already been built.

KOLBE:

You ought to be working to maximize the international donors that -- for these unmet needs.

DYBUL:

We agree completely and, in fact, we work hard at that and work closely with the fund and try to get increased resources to make up for some of those shortfalls. Unfortunately, they aren't there right now.

KOLBE:

Let me see if my time -- although I was a little late turning the thing over for myself here.

Let me -- thank you, Ms. Lowey, for giving me a pass on that.

Let me just ask you a question, one other question on the Global Fund before I pass the baton along here.

You've mentioned that our contribution -- as you know, our contribution was $544 million this last year. Do you expect that the contributions from the other donors are going to be sufficient that we can release our full contribution in the year 2006?

You know the legal requirement, limitation that we have that ours can be no more than one-third of the money collected and spent.

So is there going to be two-thirds, a match that will equal that to allow us to release the full $544 million?

DYBUL:

We hope so and we will work hard to make that happen.

Approximately $1.4 billion still needs to come into the treasury of the fund before July 31st...

KOLBE:

How much?

DYBUL:

$1.4 billion, but that's not...

(CROSSTALK)

KOLBE:

... that far short of...

DYBUL:

... that far short of what would be necessary for us to contribute our full amount.

However, traditionally, 80 to 90 percent of the resources come in during the months of June and July, so we're still hopeful that, that will occur.

KOLBE:

OK.

Is the fund engaging -- I'll come back to those questions.

I have a series of questions about other things.

Ms. Lowey?

LOWEY:

Thank you.

As I stated before, I am concerned about the role in which the 33 percent option only target, not prevention funds, is affecting other prevention interventions. And the 5 million new HIV infections in the last year, it's clear as stated in the OGAC annual report that we cannot treat our way out of this pandemic.

And I understand that OGAC is implementing the 33 percent target program-wide, which has posed problems for some country teams. Certain country teams are eligible for waivers of this requirement, but other country teams are required to pick up the slack to meet the overall 33 percent spending target.

A couple of questions.

How many country teams have applied for exemptions and how many were granted exemptions?

DYBUL:

I believe 10 countries applied for exemptions and all received exemptions.

LOWEY:

And what types of problems did they cite in reaching the targets?

DYBUL:

It's highly variable and depends on the country.

I would point out that every country is eligible to submit a waiver, or it's not actually a mandate, it's guidance. And all countries are welcome to submit justifications for why they would not meet that.

Of course, we do have to meet the number, so we need to look at that. For example, there are some countries in which the epidemic is in a heavily-concentrated portion of the population, or what's called a concentrated epidemic -- for example, among prostitutes or intravenous drug users.

In such a circumstance, decisions have already been made between prostitutes and clients about what activity they will engage in. And so data demonstrate that if you concentrate much of your prevention activities on certain activities, such as heavy condom education and also fidelity, you can have an impact.

And so it's all based on data. What is the nature of your epidemic? What's the nature of the necessary response to the epidemic using data and epidemiology as a decision point?

LOWEY:

Well, what country teams have been required to pick up the slack?

DYBUL:

Again, I wouldn't personally pose it as picking up the slack.

We look at the overall program and we have not had any country request a -- have a justification for why they couldn't meet it who have not met it.

So we don't look at it as picking up slack. Everyone is allowed to submit a justification for why they would do things differently. We have to look at the overall picture and make...

(CROSSTALK)

LOWEY:

Correct.

DYBUL:

They have matched so far by just being able to meet the justifications that have been requested, so...

LOWEY:

But you said 10 asked for exemptions.

DYBUL:

Ten asked for exemptions.

LOWEY:

So if 10 asked for exemptions and you have to meet an overall percentage...

(CROSSTALK)

DYBUL:

The 10 asked for exemptions within a context of people having already had submitted their plans, so we didn't ask for exemptions and then go back and recalculate things.

Countries all submit plans at approximately the same time. And so when all those plans came in, we were able to meet all of the plans' requests.

The justification comes in with the request. So we didn't have to go back and say, "Well, we've decreased them so you have to increase your activity." It all simply works out to where we would just meet that mark.

LOWEY:

Well, following up, have these country teams had to cut other prevention activities to make room for more ABC activities? And I'd be interested in knowing what sort of countries -- what kinds of programs were cut in those countries and what were the criteria by which the programs were chosen?

DYBUL:

Well, again, "cut" is not a word we would probably use, because as you pointed out, there has been significant increase in all programming.

And what the countries have done is within the constraints of their budget, and that's why I mentioned in the opening statement that in the absence of the full funding amount, people do need to make tradeoffs because we don't have money to do everything.

And if we had, had the presidential request last year for all the focus countries, none of these tradeoffs would have been made; that they would, in fact, have been able to meet all of them.

But they have to be within the total prevention parameter and then within the different parts of that overall. So countries have not necessarily had to cut

anything, they've just not been able to expand things.

And they choose within their program. We do not make those decisions here in Washington. We're not able to do that.

LOWEY:

Well, countries and country teams have to be responsive to local prevention needs and cultural norms. And I wonder if you can comment on the country teams' efforts to implement integrated prevention strategies and whether, in your judgment, the application of this policy has limited their overall planning?

DYBUL:

Well, we believe maximum flexibility is always desirable.

No one did national-scale for prevention, care and treatment prior to the emergency plan except for a very few countries. And so we learn as we go, as the congressman mentioned. And so maximum flexibility allows for that type of flexibility.

One of the things we have learned relative to what the chairman was asking about is we now learn from Kenya and Zimbabwe that clearly the most effective evidence base, adding on to what we knew from Uganda, is A, B and C together; that the data are crystal clear.

And I have, as a scientist, reviewed the data from both Kenya and Zimbabwe that became available this year. And it's very clear that it's very much like Uganda -- partner reduction, increased age of first sexual onset of activity, particularly among young people, also some increase in condom use. You need all three components.

And so what the country teams do is within their budgets try to enhance all three of those components to the best that they can, bringing in other global partners where

necessary.

So we leave it to them to work with their partners because it's the national program to see which pieces we will support, to see which pieces others will support, as we all support the ABC program because we know the data are there.

LOWEY:

Thank you.

KOLBE:

Thank you.

Let me just say to the committee, although two bells and five bells have rung, we expect only one vote.

I'm going to take Mr. Rehberg's time for question.

Mr. Knollenberg should be back about the time we recess this hearing and we should go to somebody over here.

So if you people want to go and vote and make sure there is only -- wait until we know there's only one vote and then return, we can speed this up and not lose too much time.

Mr. Rehberg?

REHBERG:

Thank you, Mr. Chairman.

And I'm not going to be able to come back so I appreciate your allowing me this opportunity. I have an amendment on the floor next.

I asked the question specifically last year which countries were not fulfilling their duty or their requirement and it was kind of about the time of Katrina and we were being attacked -- not Katrina -- Indonesia -- we were not maybe playing ball as much as we should, and I wanted to check and see if some of the countries that certainly weren't doing enough in Indonesia were some of the ones that weren't doing enough toward this effort.

The country Italy was the one answer I got, I think, from Dr. Tobias.

Is it still -- are they -- have they paid?

DYBUL:

Italy has actually met its contribution to the Global Fund, I believe at least through 2005. I don't know about 2006 and whether or not they have met their pledge.

But again, the pledges for '06 of which we still need another $1.4 billion, there's still time to get those dollar amounts in. So I'm not sure which of the countries have not yet put their pledges in yet, but most of them haven't because 80 to 90 percent haven't...

(CROSSTALK)

REHBERG:

I just wanted to close the loop.

The second point I wanted to make is, are you familiar with Rocky Mountain Technology Group out of Billings, Montana?

DYBUL:

I am, yes.

REHBERG:

What do you think?

Do you think it has the potential or the opportunity to expand into some of the other countries? It's pretty exciting what they're doing for Uganda, because, you know, they're not just selling them technology; they're actually training the individuals on how to monitor.

And, Mr. Chairman, that was the group I talked to you about and hopefully some day we can get a hearing, we could have an opportunity to hear from the CEO, because it's phenomenal the information they collect.

And I'd just like your reaction to what they're doing.

DYBUL:

Well, as the chairman mentioned, monitoring and evaluation is a critical component of this program, both to provide information so that we can justify the increased resources, but also so that we can program better, that we can learn lessons and program better.

And the program you mentioned is a very good program. A number of other countries have also developed very exciting technologies to monitor and evaluate

their programs.

Rwanda, for example, right next to Uganda, has a very exciting program that allows every site that enrolls someone in anti-retroviral therapy to be in the system and you can actually monitor and see whether or not people are being treated appropriately.

South Africa has developed a very exciting system as well, using smart cards and some other projects, so you can follow people from clinic to clinic because there is so much migration.

So there are a lot of exciting technologies in monitoring evaluation. But because we respond to local needs and local systems, it's different in each country, but we look to expand the programs that work to other parts of the world, not only within the focus countries but globally, which was the nature of the focus countries; like to learn how to do national scale-up of prevention, care, and treatment, and then use those lessons so the rest of the world can do it as well.

REHBERG:

Well, I appreciate that answer, because we want to know the money we're spending is being used efficiently and effectively.

And without that kind of monitoring, you've got 15 countries, if you've got three, or four, or five that are doing it, why aren't the rest?

That ought to be a requirement soon so that we know exactly where it's going. Is it getting to the people it needs to be getting to? Are they taking their medications and such? And may be an opportunity to have a hearing with the three different countries' technology providers.

DYBUL:

I want to clarify.

I gave those three as examples.

Every country is establishing a monitoring and evaluation system within the focus countries and beyond because it is an essential component of an effective program.

REHBERG:

Thank you, Mr. Chairman.

KOLBE:

Thank you.

Mr. Fattah thinks he can get his one question in the remaining time.

(CROSSTALK)

FATTAH:

Doctor, let me -- one of the things that's been missing thus far in the discussion, aside from the ABC, is this question of safe blood and the safety of the blood supply.

And with the chairman's help in a bipartisan way, this committee created some language that required you along with a number of other entities to prepare a plan to create a healthy, safe, sustainable blood supply. That plan, as I understand it, is on track and is going to be finished, at least a preliminary draft, by the end of this

month.

But I note that there are, outside of the ABCs, that there are other ways of people getting AIDS and HIV -- millions of them -- and it's through blood transfusions, through unsafe blood supplies.

And this committee is very concerned about it. We wanted to know whether you would comment on where you are with the plan and what you're doing about making sure that this doesn't get lost in this discussion about abstinence and condoms, when we have kids who are getting bitten by mosquitoes and get malaria and need blood transfusions. And there, HIV has nothing to do with abstinence or condoms or anything else.

KOLBE:

Mr. Dybul, we'll have to get your answer, if it's a longer answer, when we come back. I can give you 60 seconds right now, that's all.

DYBUL:

I would just say that blood is one of the mechanisms of medical transmission, which is why about half of our prevention resources go for sexual transmission and the other half are -- a little bit less actually than half -- 45 percent or so go for medical transmission, prevention mother-to-child transmission, safe blood, safe medical injections.

We are working hard on blood safety, as I mentioned. Six hundred safe blood sites have been supported. Eight thousand people have been trained in safe blood under the emergency plan.

It is a very important area that we take very seriously.

It is certainly, though, not the main mechanism by which people get infected in HIV in Africa -- India may be a different story.

But we are working hard on it. Some countries are there. South Africa has a clean blood supply. Botswana has a clean blood supply. Kenya will get there soon. And we're doing an awful lot to support and we will have the report in on time.

FATTAH:

All right.

Thank you very much.

KOLBE:

Thank you very much.

The subcommittee will stand in recess for a few moments here.

(RECESS)

KNOLLENBERG (?):

The subcommittee will come to order.

And, Dr. Dybul, thank you very much for appearing.

I'm just a stand-in for a moment. Mr. Kolbe will be back.

I had a question for you in regard to this whole idea of effectiveness and efficiency and sustainability. It's something that I'm very interested in -- I know that you are, too -- in hearing you describe some of the challenges that are coming forward in the next few years with respect to help.

How long can this money stretch out? It looks to me like you're saying we need more money down the pike, and the pike isn't that far away, in a couple of years.

This year, I think, the increase has been 20 percent. Is that right?

And as we move forward with this plan to address the HIV/AIDS pandemic around the world and in the specific focus countries which you've outlined, I think we have to make sure -- and I know that you do, too -- that this money is spent effectively and efficiently.

What kind of targeted evaluations and operations research have you done recently to judge the effectiveness, the efficiency and also the sustainability of our programs?

Sustainability I think is the important word here.

Would you care to respond?

DYBUL:

Yes.

Targeted evaluations are an important part of the work we do.

We actually have an interagency working group on targeted evaluations that includes many parts of the U.S. government, including our National Institutes of Health because of their expertise in this area.

A number of the targeted evaluations that we're doing at the moment is to evaluate the actual cost of treatment over time. No one has evaluated what happens over, say, a two-year period. Is there a necessary infrastructure cost that is very high and then the price comes down over time? Or because of necessary ongoing education, training, reagents for laboratories, updating the laboratories, does the cost not come down significantly over time?

We think that will be very important as we look to see what is the need for resources over time.

Another important targeted evaluation that's being done is adherence. How do you most effectively do adherence education so that people take their drugs when they're supposed to? Because if you don't take your drugs when you're supposed to, the risk of resistance is very high.

There's a targeted evaluation looking at prevention methods and how can we most effectively target prevention activities and what are the most effective means of causing behavior change.

There are three important targeted evaluations being developed right now which actually look at new programmatic approaches with a targeted evaluation component.

One of the things Ms. Lowey mentioned, which is very important, is gender-related to HIV/AIDS, and she's quite right that gender issues, cultural issues can have a significant impact on the transmission of the virus, nonprevention activities.

We do not know what the most effective interventions are related to gender. Is it targeting transgenerational sex? Is it targeting empowerment of women in different ways? Is it targeting different behavior change modifications in the community? Is it the reduction of polygamy? We don't know those things yet.

And so we're going to do, at the same time, programmatic -- targeted programmatic interventions but also evaluate at the same time to try to evaluate what the most effective mechanism is.

Alcohol is an example of something particularly in sub-Saharan Africa, particularly in Namibia, Botswana, South Africa, but also other places that can be driving the epidemic.

Again, we don't have a sense, even though we're doing some programs on this, of what the most effective programs are so we're doing targeted evaluations related to that.

KNOLLENBERG (?):

How effective on the prevention side have you been?

Your judgment -- is prevention going to be a core part of your program in terms of bringing down, hopefully, the cost?

DYBUL:

Absolutely.

From a pure cost perspective, we will not won this fight unless we're preventing infections.

Every time someone gets infected, they need care and treatment. But more importantly from a humanitarian perspective, every infected person, even if they live a normal life span with treatment, has psychological impact on them, has an impact on their family. There is morbidity.

And so prevention is the foundation of the emergency plan, and I have to say, one of the great insights of the emergency plan is integrating prevention, care, and treatment. It really was the first international initiative that outright said you can't focus on one or the other; you need to bring them all three together.

KNOLLENBERG (?):

I would think prevention would be an earnest part of your scope, vision on this whole thing.

NIH perhaps contributes to that at all or no?

It is a prevention program, one that you've initiated, that's your baby, so to speak.

DYBUL:

Well, all our activities are to support national strategy and local programs.

And what we use things, for example, like NIH and other scientific activities for is to document the most effective mechanism which we then implement. And so, for example, the data are very clear that ABC is the most effective means to prevent sexual transmission in a generalized epidemic. And so we take those data and implement programs based on it.

We also -- as I mentioned, NIH participates in our target evaluation subcommittee. NIH also has a number of studies and research sites in Africa that have capacity where it's not too difficult to build prevention, care and treatment activities into these places where the U.S. government is already invested. And we're doing that in a number of countries as well.

Again, one of the insights to the emergency plan was to bring the whole U.S. government together, not as individual agencies, but as one strategic approach to combat HIV/AIDS.

KNOLLENBERG (?):

Relative to the '07 fiscal year, how much of the requested budget is for targeted evaluations and operations research and how will that be divided between the country programs, the central programs and strategic information evaluation?

In other words, have you established your number as to how that will be targeted?

DYBUL:

It's spread somewhat.

I believe it's approximately 32 million or somewhere there about for strategic information services, which is many components -- health information services, epidemiological surveys that are necessary to understand what's going on with the epidemic.

In addition to that, there are resources for targeted evaluations, both at the central and in-country level. And so I don't know the total when you put all those different pieces together right now, but we could help identify that for you.

Some of it we will not know until September of this year when the countries submit what they would like to do with their available budget.

KNOLLENBERG (?):

Thank you.

I believe my time has probably expired here, and I see that we do have a returning member of the subcommittee, so I believe you're in line.

Ms. Kilpatrick will be recognized now.

KILPATRICK:

Thank you, Mr. Chairman, chairmen from both my committees.

Good to see you.

KNOLLENBERG (?):

Temporarily.

Thank you.

KILPATRICK:

Good morning, Doctor.

How are you?

DYBUL:

Good morning.

KILPATRICK:

Thank you very much for what the Global Fund does.

I just returned with 11 members from Congress in four of those countries where the Global Fund is working. Very high praises for what you do and how you do it and the partnerships that you've built.

Can you back up for me and tell me the structure. I understand it's four or five, now, cycles that the fund has been funding? You had some organizational problems. There are no problems -- changes is a better word.

Is there an executive director in place that's permanent?

DYBUL:

Well, Ambassador Tobias, who is the U.S. global AIDS coordinator, had his hearing actually on Tuesday.

The president has nominated him to be the new director administrator of the U.S. Agency for International Development, and also Secretary Rice has appointed him to be the director of foreign assistance for all of the U.S. government.

KILPATRICK:

Can he do both?

Can he do both? One or the other?

DYBUL:

He has been nominated to have a dual hat in both positions -- nominated for one and appointed to the other.

So our office, Ambassador Tobias is still the coordinator pending congressional action. And at some point, the White House, the president will nominate a new coordinator for our office.

Ambassador Tobias has set up a very solid organizational structure so that it's not dependent on an individual person. While we'll miss him greatly, the structure is in place to ensure a very smooth transition.

KILPATRICK:

And the board -- is the board -- how many on the board and is it fully complimented?

DYBUL:

The Global Fund -- the Global Fund board consists of donors, international, nongovernmental organizations, community representatives and also recipient countries.

I don't know the current size of the board. It's not small, I can tell you from...

KILPATRICK:

No, it's quite large.

(CROSSTALK)

KILPATRICK:

... by statute, I do recall.

DYBUL:

Dr. Feachem is still the executive director of the Global Fund. He has not announced his resignation. He's announced that he will not seek another term. So the board will go through its normal cycles to appoint a successor to Dr. Feachem.

KILPATRICK:

And when is his term?

He's done a good job as well.

DYBUL:

His term expires, I believe, over the summer, but the board will determine the next steps in terms of when a new executive director would come in.

KILPATRICK:

OK.

DYBUL:

There's a board meeting in April.

KILPATRICK:

I see.

And I understand they meet quarterly or semi-annually or something like that?

DYBUL:

The board meets at least semi-annually.

There are many committees, including the Program Services Policy and Strategy Committee, that meets more regularly. And then the executive board meets -- the board meets both in executive committee and full board.

KILPATRICK:

In the countries where we visited -- and I mentioned those 11 members went over this last break that we had -- and all of them spoke highly of the partnerships. And you mentioned the in- country requirement that each must have as the Global Fund goes into assist, not to take over, and I think that's a good adage to work from.

They all spoke about the treatment and PEPFAR particularly. Now, my understanding is PEPFAR -- are the accounts pulled under one or is it separate from? How does it relate to the overall global AIDS?

DYBUL:

PEPFAR is all accounts the U.S. government has on HIV/AIDS together, including our contribution to the Global Fund.

As I mentioned, we're still the largest contributor to the Global Fund and we're very active in the board of the fund, the committees of the fund, the subcommittees of the fund, secretariat and the board, but also very active on the ground in supporting the Global Fund, particularly technical assistance to ensure that grants are moving and are succeeding.

So the Global Fund is a part of the U.S. government strategy on HIV/AIDS, which is a part of PEPFAR.

KILPATRICK:

I see.

And the $700 million that we're asking for today in the president's request, that would bring it up to what number were you saying?

DYBUL:

Approximately $4 billion.

KILPATRICK:

OK.

And is that adequate we think?

Again, the largest contributor in the world (inaudible) and to meet the need and demand, is that...

DYBUL:

Well, there's always a need for more.

This is a global epidemic that requires a global response, and so the U.S. government is certainly doing what it should be doing with this $4 billion request.

In 2004, when the United States was providing approximately $2.4 billion, we were about half of what the world was providing -- a little more than half.

There has not been the type of leadership to follow the American people's leadership on AIDS, so as we get the $4 billion, we will be well in excess of half of what the rest of international governments are providing.

KILPATRICK:

On that point you just mentioned, as U.S. is the leader in dollars, I think our country is lagging way behind in terms of education and mobilizing, and I hope that we'll be able to -- we as a country and we as leaders of this Congress and throughout the country will be able to bring more attention to our own domestic AIDS crisis, which is really growing in many communities around the country.

Lastly from me, Mr. Chairman, as we visited those countries and talked about Global Fund and PEPFAR and how successful it is and how happy they were to have it, (inaudible) your remarks, treatment is what you do.

We also find that poverty, lack of education and those kinds of things really perpetuate astounding numbers because of the lack of that. Have you found that in your research? Have you found because your mission is treatment that sometimes the other things that affect poverty, like education, lack of clean water and food and diet -- do they impact your work?

DYBUL:

Well, we do prevention, care and treatment, and all three are very important.

And there's no question the environments in which we work, as Congresswoman Lowey mentioned, are impoverished countries for the most part and issues such as water and food are very important issues. And that's why the U.S. government has a broad development response and is reflected, in the fact, that Ambassador Tobias will be leading these efforts, because there is an integration of an approach.

Our particular mission is directed toward HIV/AIDS, but fits into the larger administration approach in all of these areas.

And so we do, do some nutritional work. We do, do some water support. We do, do a lot of orphans and vulnerable children work, including supporting education as it relates to HIV/AIDS. And other parts of the U.S. government pick up the other parts of the response to those pieces of development.

KILPATRICK:

OK.

For the last time, Mr. Chairman, since we're a little late, Africa for sure, the former Soviet Union, India -- where else are we seeing high prevalence of HIV?

DYBUL:

The highest prevalence is still in Africa by far.

About 70 percent of the disease -- there are several countries there that have populations where the adult population is a third infected, and so those numbers

are the highest anywhere.

But we are seeing growth of epidemics in parts of Asia and the former Soviet Union and those are places that people are watching very carefully.

But in terms of current prevalence, heavily, heavily still Africa.

KILPATRICK:

And the same applies in terms of the infectious rates going up?

Trying to contain it in one place is not infectious, but it's pandemic. Trying to contain it is the same problem where we have (inaudible) learned anything from any of the places that would contain other than education, abstinence, partners, condoms? Those remain the...

(CROSSTALK)

DYBUL:

The data are very clear that on a generalized epidemic where the epidemic is in the entire population, like Africa -- every part of Africa, except for one or two places -- the most effective means is attacking sexual transmission because that's how the virus is mostly transmitted, over 90 percent of the time.

As we mentioned a little bit earlier, there are pockets of the world where that is not the principal mode of transmission.

KILPATRICK:

What is it?

DYBUL:

Asia, for example.

There are parts of Asia and the former Soviet Union where intravenous drug use is the main propeller of infection.

There are still places that have concentrated epidemics in Asia and other parts of the world, so the identifiable populations where 80 to 90 percent of the infection exists, for example, in prostitutes and drug users and things.

So it's very different in many different places, and we have learned many lessons in different parts of the world about how to attack different modes of transmission.

It's not anywhere near complete. The picture's not anywhere complete, but we have learned a great deal and those lessons are being applied.

KILPATRICK:

Thank you very much.

Thank you, Mr. Chairman.

KOLBE (?):

Thank you.

We'll begin a second round of questioning when Mr. Rothman comes in. We'll take him whenever he does get in as the next person here.

I want to go back, if I might, to the Global Fund, which I started with and I had a couple of other questions.

I know there is an effort being made to encourage outside private donations to the Global Fund. In fact, I think a program called Product Red was recently announced. The purpose is to deliver a sustainable flow of private-sector money to support Global Fund programs. You're aware of it, I'm sure -- you nodded.

Do you have any idea about the estimates of the amount of funds it might raise? Is the fund engaged in other efforts to get outside nongovernmental partners in donations? And are there any limitations on the dollars that the funds can accept from outside sources?

DYBUL:

We are very strongly supportive of private contributions and private efforts to support the Global Fund.

It was established as a new model, including public/private partnerships and public/private contributions.

To date, I believe $156 million in private resources have gone to the Global Fund.

However, $150 million of those so far come from a single foundation, the Gates Foundation. And so that indicates that there's a long way to go in terms of raising additional private funds, and we believe that there should be an emphasis in fund raising for the Global Fund for a sustainable response.

Efforts such as the one Red Campaign we think are important to look at -- innovative approaches to raise resources from the private sector to contribute to the Global Fund.

I haven't seen an estimate. I'm sure we could get one for you, and you have contact with those, of how much they expect to raise from that. As you know, it's a percent of utilization from a credit card with certain companies. But we think that's an extraordinary effort.

We are not aware of any restrictions on raising funds from private sectors. There is some discussion about in-kind contributions as opposed to cash contributions.

But I'm not aware of any restrictions on cash donations to the Global Fund from the private sector. But we would strongly encourage this as an avenue of resources for the Global Fund.

KOLBE:

Thank you.

I want to turn to the supply chain issue, something I'm very interested in.

My understanding is there is a contract that's been rewarded -- I think it's a $7 billion ceiling contract to manage the supply train of the anti-retrovirals, test kits, other commodities that are used in the programs.

Please give us an update on the status of that contract. How much has been put in the contract to date, the number of subcontracts, problems or challenges that it has?

And I'd also like to know what the processes for getting new and innovative commodities onto the approved products list and how do you safeguard the quality control for those products that are approved?

DYBUL:

Thank you very much for that question.

As you know, the award was given -- for that contract was granted in November to a consortium of 14 or 15 groups. They exist. They have an office and they are very active.

In the operations plans for 2006, some of which has been put forward in the congressional notifications, I believe approximately $40 million or $50 million so far has been designated by the countries for use in the supply chain management system.

The supply chain management system is a very capitalistic system. It's a voluntary-use system. No one is required to use it and so some of it will depend on what the countries want to do -- getting back to local capacity and supporting supply chain development in-country.

The teams are very active from that consortium. In fact, they've been to the field almost nonstop for the last couple of months. They've just returned from Guyana, I believe, and on their way to Mozambique today, I believe.

So they are working with the countries to build their supply chain systems and to provide a resource for pulled purchasing and financing.

Getting to the issue of why we needed to do it and why we have the system is at the moment we're supporting around 400,000 people in treatment in the 15 countries and we need to get to 2 million. And one of the principal impediments are systems, and supply chain management systems are one of them.

And I know you have been to the field and have seen the nature of the existing supply chains, and that we cannot get to 2 million people in 15 countries with treatment and care. There are 120 commodities and products that we hope this system will cover, not just anti- retroviral products. And so those need to move through a supply chain and that's what we're trying to develop there.

To ensure the quality of the products is a very important part of what we do.

We believe that everything we provide to people in Africa should be the same quality that we provide to the people in the United States. And so we have, as you know, the FDA tentative approval system which has to date, as of today, actually approved 16 drugs.

A new triple -- a combination, two-drug combination with a third drug and a blister pack was approved just yesterday, which is another exciting -- that's the second of these blister-pack combinations that we have.

And so we have a process to ensure the safety and efficacy of products as we use them, and we think that's a very important step.

So we are ongoing looking at quality, not only the quality of the products but the quality of the supply chains, to make sure that the supply chains are in place so that there won't be interruptions in products, that people will get their drugs at a regular basis and not just in cities, but in the local community areas and the rural areas.

KOLBE (?):

Thank you.

I appreciate that. And I agree with you, that the supply chain is absolutely a critical component of making this whole system work.

Ms. Lowey?

LOWEY:

I mentioned during my opening remarks my concern that Congress has decided not to battle with the administration, just to level fund the critical developmental interventions that will ultimately make PEPFAR a sustainable success.

I think we know that combating AIDS is not only about narrowly- focused prevention messages and anti-retrovirals, it's also about sending kids to school, sending girls in particular to school, ensuring adequate nutrition, providing economic opportunity, ensuring the availability of non-AIDS health interventions.

There are numerous accounts of people who are fortunate enough to be enrolled in ARV programs but do not have the means to purchase food or access clean water.

We have heard of programs that successfully prevent mother-to- child transmissions of HIV/AIDS only to have those children die months later from diseases that could be prevented by a 10-cent vaccine.

OGAC has recently referred to a wrap-around approach to address these related programs, yet your annual report has just two paragraphs defining this approach in a 166-page document.

How do you reconcile the administration's commitment to fighting AIDS with its consistent efforts to cut funding for other key health and development interventions?

DYBUL:

Well, I can't comment too much outside of the AIDS arena.

I can say that this administration has been the strongest administration I have seen in terms of supporting development overall, doubling assistance to Africa, massive debt relief which goes to support the ability of countries to combat some of their endemic problems.

And so overall this administration I believe, has been the strongest development administration since John F. Kennedy.

So this is something that is being addressed and Ambassador Tobias of course is going, we hope, to head USAID, depending on the actions of Congress, and also to

serve as the director of foreign assistance to help all of these things.

Our particular mandate is HIV/AIDS, and there are many things that influence HIV/AIDS.

Long before there was HIV, there was poverty in the countries that we work in and there was hunger in the countries that we work in.

And so we work to support the pieces of nutrition, education, water that are directly related to HIV/AIDS, and some of them we do directly fund. For example, support for 1.2 million orphans and vulnerable children, 52 percent of whom are girls. And that includes support for school uniforms, education, food parcels, things that support their activities and abilities to live as normal children.

We support nutritional programs within anti-retroviral therapy, particularly for those who are malnourished as they begin anti- retroviral therapy for a limited period of time.

But no one program is going to solve all of the problems of the world unfortunately. We are focused on those that are related to HIV/AIDS and work with the other agencies.

Congress -- this committee has asked for and we will provide you with a report on how we intend to address nutrition.

We have an excellent working group that has representatives from the U.S. Department of Agriculture, USAID and other parts of the government that are actively engaged in these activities so we can bring them together.

We work closely with the World Food Program. For example, in one of the congressional notifications, there's significant resources in Ethiopia, a highly food-challenged environment, so that we can use our resources to bring food to (inaudible) and bring food to HIV-infected people.

So it's this type of leveraging.

We certainly need to do a better job of communicating it, but it is very much done on the ground, and we pick up the HIV/AIDS piece and look to the rest to pick up the other pieces.

LOWEY:

I must tell you that I happen to agree with you, that this administration has certainly committed itself in dollars to advancing a whole range of international interventions, in addition to HIV/AIDS.

Certainly, we've had many conversations about this in the committee. I've been in support of the Millennium Challenge Account.

However, in these initiatives, as he has discussed them, it -- originally, they were all going to be additive.

Now, I understand the president proposes, the Congress disposes. I've heard that before. But I would think with this important HIV/AIDS initiative and the important Millennium Challenge Account initiatives, that the administration would use its influence in making sure that these initiatives are additive and that they don't take away from basic development programs.

So I appreciate your comments and I hope that we can work together to ensure that the integrated approach will continue to be advocated and that we can prevent further cutbacks in some of the very, very important development programs.

Please discuss this with the secretary, because certainly when the ambassador and the country team at USAID meet on their priorities in the five-year development plans, it's very important in my judgment -- and I can hear from your comments in your judgment -- that there really is an integrated approach and we're not cutting back.

Certainly with regard to nutrition, you mentioned the commitment but we know that the World Health Organization recently released guidelines on nutrition and anti-retroviral therapy concerning that nutrition is essential to treatment.

And I would hope -- and you commented on that -- that you will be providing the report to us as requested in the FY '06 foreign operations bill on the impact of food and nutrition on care and treatment.

Another related issue: family planning.

Is PEPFAR incorporating family planning into counseling for those who are found to be HIV positive? How much is PEPFAR currently spending to provide contraceptives?

DYBUL:

In terms of the total dollar amount on contraceptives, I don't know the dollar amount. I can tell you the numbers, though.

In 2001, the U.S. government supported approximately the supply of approximately 350 million condoms globally, and 115 million in the focus countries.

In 2005, it was 470 million globally and around 200 million in the focus countries.

So our support for condoms has increased in the context of an ABC program.

I don't know the dollar amount attached to those, but I do know the commodity number and we can try to provide you with the dollar amount as well.

In terms of family planning, we actually just sent a note in response to an inquiry on this to outline again, which we have done before, that there are links between voluntary family planning and HIV/AIDS, and that we support those linkages.

We strongly encourage the use of HIV/AIDS testing, for example, in all family planning clinics because it's an opportunity -- it's an excellent opportunity to access young women to get them engaged in HIV/AIDS through counseling and testing, and linkages between the types of programs.

So we've outlined this again. We'd be happy to provide you with the letter, but we have provided that type of guidance in the past as well.

LOWEY:

And I know my time is up, but if you could provide examples...

Pardon?

KOLBE (?):

(OFF-MIKE)

LOWEY:

OK.

Just to close that area up, if you could provide examples of instances where AIDS family planning programs are being wrapped around ongoing PEPFAR programs, I think that would be helpful because I've been concerned that the president's FY '07 budget, the family planning programs are being cut.

So it would be helpful to us to know examples and how it's working and are they effective.

And I thank you.

DYBUL:

I can give you one now.

Kenya has done an announcement that combines family planning and HIV funds in a large effort, and this is not an uncommon occurrence.

But we can provide you with more examples.

LOWEY:

Thank you very much.

KOLBE (?):

Thank you, Ms. Lowey.

We will come back with a final round of questioning, but I would like to give Mr. Kirk a chance. He hasn't had the chance to ask questions yet.

Mr. Kirk?

KIRK:

Thank you, Mr. Chairman.

And, Dr. Dybul, thank you for coming.

I am concerned that under the base authorization legislation that governs this program, we are too rigid.

For example, I think Ms. Lowey was talking about lanes -- that a certain percentage had to be in prevention, a certain percentage had to be in treatment, et cetera, which may not address the needs of individual countries.

The touchstone for this program, in my view, and I think the president's view and the Congress' view, is net lives saved. And so these rigid categories may actually reduce our ability to save lives.

My understanding is that we've had requests for waivers from individual country programs to adjust the amount spent. But you are not able to waive for the overall program.

And therefore, if we were to boost prevention funding in one targeted country, that means we have to lower treatment funding in others so that you hit the overall target? Is that how you understand the financial management of your program?

DYBUL:

I would have to say yes and no.

Because we're requesting such significant increases from year to year -- and really we've gone from $2.4 billion in 2004 to the president's request for $4 billion -- it's less a matter of decreases than increases in different program areas.

So it's not really decreasing activity. Even as we go from a time when the U.S. government did almost no treatment at all, prevention, to a time when only about 20 percent of our resources were on prevention, we're still dramatically increasing the total dollar amount that's available.

And one of the reasons we are so strongly encouraging full funding in the president's request for the bilateral program is so that we can meet all of these pieces, so it's not through decreases or anywhere but increases in all activities.

But it is true that in 2006, according to the authorizing legislation, the marks in terms of percents are absolute, not (inaudible) as a Congress.

KIRK:

Mr. Chairman, I'm wondering, you know, one of the things I think our subcommittee should look at is allowing these country waivers to be granted so the program is more appropriately adjusted to increase the number of lives saved and not count against the overall target; that once a waiver is issued, a waiver is issued.

Because I would hate for a dramatic situation in Uganda to trigger you to rightly adjust the percentages and then for you to have to somehow boost funding in another program in another country simply to hit an artificial target rather than to make sure the programs are adequately adjusted for each country so that you're saving the most number of lives.

The second issue: When my predecessor and I and Congressman Mrazik (ph) started this program back in 1985, we realized that prevention was the lowest-cost way especially in a developing country environment to save a life. But we didn't want to make a treatment commitment.

In your testimony you say that a $55 million reduction would drop 39,000 people from treatment, which shows that your average cost of treatment you assume is $1,410.00 per patient per year.

When I look also at your testimony, you say the United States is committed to treating 471,000 people at an average cost of $1,400.00 per patient.

I'll sort of create a phrase. We have a moral baseline in this program now, "but for us this patient would die" commitment of $664 million per year to sustain a commitment to this patient population.

Is that about how you would figure it?

DYBUL:

There is certainly going to be an ongoing cost to maintain therapy for patients over time.

As I mentioned a little bit earlier before you were able to join us, the cost over time is unknown. So we are actually doing a targeted evaluation to see what happens over time to the cost of treatment.

Is the initial infrastructure cost need in a country where you have to basically build a lab and trained everyone, and put up reagents, is there a huge cost that then comes down over time?

The current average cost is $1,400.00.

It's been evaluated and actually published in the New England Journal of Medicine and other places. We're trying to see if the cost comes down over time.

My guess is it's not going to come down very much, and the cost of second-line therapy and other things will make up for any gains we might make.

But we have to look at that. But there is no question that there will be an ongoing cost to maintain treatment for HIV-infected people once they begin.

KIRK:

Let me get to the point.

But just so the committee knows, what is the per-capita health expenditure? Roughly, give us a swag for Uganda.

DYBUL:

I believe it's in the dollars, not hundreds of dollars.

It's very low.

KIRK:

So there is no realistic hope whatsoever within our lifetime of local resources being able to sustain this commitment?

DYBUL:

I hope we live long enough where that would not be the case, but yes, it would be quite a while before an Uganda themselves could pick up the cost of such therapy.

However, that doesn't mean the United States itself should be bearing the cost, and we believe that the current distribution of resources for the United States is not quite right; that the rest of the world needs to respond in the same way as the leadership of the United States.

And also, as Ms. Lowey mentioned, there should be ongoing efforts to debt relief and other things the administration is engaged in to build the economies of these countries so that they can ultimately pick up more and more of their costs.

KIRK:

But here's my point.

But for the international community, this patient will certainly die because there's no way local resources can match this commitment for the foreseeable future.

DYBUL:

I believe that's correct...

(CROSSTALK)

KIRK:

And then, has this been cranked into OMB budget projections?

Because this is a sacred commitment to half a million human beings and I guess, on average, they're contracting the disease in their teens, probably likely to live into their 60s. So this is a 40- year financial commitment by the United States to keep this person alive.

DYBUL:

Well, I'm not able to comment on these budget calculations. Fortunately, I'm not very good at things like that, those numbers.

But it is well understood and was understood at the beginning that this was a long-term quantum leap in commitment by the American people to support activities around HIV/AIDS.

KIRK:

Yes, and a probably four to five decade commitment per person.

DYBUL:

It is an ongoing commitment.

KIRK:

Yes.

Thank you, Mr. Chairman.

KOLBE (?):

Thank you.

Mr. Kirk's raised a very interesting line of questioning there and I think it's a very important one, that we do assume with this responsibility, with doing this, a long-term responsibility.

It also suggests -- and it's one that's only going to be met by the international community.

It also suggests that there are other costs that are associated with this that we may not have adequately thought about, because when somebody is HIV-positive, there are other kinds of health-care requirements and needs -- the infrastructure and everything else that has to be dealt with -- so it kind of spills down the chain there.

And I wonder who's really thinking about those kinds of issues?

I just pose that. It's not really a question to you, but something I think we need to be thinking about.

We'll start another round of questioning here and hopefully...

(CROSSTALK)

DYBUL:

I can say we are thinking about it and have.

They were in the original calculations and they're all in our thought processes.

KOLBE (?):

But not necessarily in the funding.

DYBUL:

Yes, actually, they are in the calculated cost.

Anti-retroviral therapy, the average cost is somewhere between $1,200.00 and $2,000.00. Of that, the cost of the drugs is probably never going to exceed 30 percent and may actually become lower.

So in all our calculations, this was included.

The other health-care needs -- that's why we have a care component, because of those other health-care needs. So they have been part of our thinking from the

beginning.

KOLBE (?):

I want to go back to the first line of questioning that Mr. Kirk had and something that I wanted to talk about and he did, but I want to follow it up, and that has to do with the spending requirements.

There are many that have said that those spending requirements (inaudible) 33 percent for prevention based on the abstinence and be faithful programs, abstinence and marriage programs, until marriage programs. The 10 percent set aside for orphans, older children; 55 percent requirement for therapeutic medical care.

But that really inhibits the ability of focus countries to direct PEPFAR to the areas of greatest need.

Mr. Kirk was suggesting maybe we need to have some kind of -- like we do with other national security waivers -- some kind of a waiver in there. Do you think that flexibility is necessary? Does this currently inhibit your -- has it yet inhibited your ability to deliver services?

DYBUL:

Well, of course, maximum flexibility in any programming is a very useful tool, particularly as we're doing something in a field that can change very rapidly.

We do believe that the directives have been helpful.

For example, we needed to shift our emphasis in prevention to a full ABC approach and that has been occurring. We needed to be concentrating on treatment because it was an important part of the initiative and that has been occurring.

So there's no question that we needed some shifting and that it's occurring.

We are operating within the requirements at the moment. We will not meet the 55 percent for treatment. We cannot meet it and still maintain all the other types of programming that need to be maintained.

So we are operating as flexibly as we can and working within them.

But I do think there is a utility to providing some benchmarks, some goals so that our people can be thinking about the most effective and evidence-based approaches.

KOLBE (?):

I would not that when you say that it's always desirable to have the maximum flexibility, those numbers -- and they are I think to a large degree some political numbers -- hopefully they have some basis to them -- but those were not imposed by Congress. Those were also asked for by the administration. They wanted the same kind of limitations. They thought that politically it would make it more saleable, and I think they're probably right.

On the same line, though, let me ask you this.

Some have argued that it doesn't make any sense for grantees to have to account for the abstinence and be faithful prevention parts, and other prevention activities separately; that it inhibits the delivery of a comprehensive, seamless plan in a country.

Do you think that's true?

DYBUL:

We've looked at this.

It's difficult for me to understand how an accountability requirement such as that actually modifies your program when the guidance on how you should be programming doesn't provide such a limitation.

The guidance is very clear on the need for integrated ABC. It's very clear on targeted populations by age and other activities for the types of things you need to do.

So I don't know that even to report on it actually has -- it should have a direct impact on programming. I think we finally do a better job of communicating around it, but I don't think the requirement itself ought to limit the ability to program the way you want to program, because you're supposed to start with the guidance on what your program should be and only after, work through the programmatic divisions of cost.

So we probably need to work on that a little bit, but I don't think there's any (inaudible) priory limitation on program from some such a limitation.

KOLBE (?):

Let me ask you this.

Earlier you said that the cost per patient for the treatment part was not just the cost of the drugs, that it was other things.

So I want to ask to you to follow up on that as it relates specifically to food assistance. We've scaled up this program pretty dramatically and very successfully, but I wonder if we're sometimes ignoring interventions that may not count against one of the targets but ought to make a big difference.

I think one of the studies have shown clear that when somebody is -- an ARV person is malnourished, we can expect that the treatment is not going to be as effective as it should be. It's not going to reach its full medical effectiveness, nor is

the patient going to be able to return to maximum productivity.

So I guess the question is, relative to the cost of the medication food assistance may not be very expensive, but I wonder what is the policy of PEPFAR with regard to the use of funds for food assistance?

Is there any of that being committed or done in any way? Are we making sure that we're combining with other resources elsewhere?

DYBUL:

Yes, absolutely.

And in fact, we'll be submitting a report -- I can't remember the exact date, but some time in the near future next month -- that outlines some of this.

Among very malnourished patients, some nutrition, at least at the beginning, seems to be useful for anti-retroviral therapy.

And we always have to balance, you know, most effective versus effective within the limitations of the cost.

So unfortunately, people will die if they don't receive anti- retroviral therapy. They will probably not die if they don't receive food supplementation. They will be hungry, but they will not die if they don't. And so this is why we're advocating so strongly for the full bilateral financing, so that we can have maximum flexibility to do as much as we can.

We do, in fact, support quite a few people receiving anti- retroviral therapy with some type of food support.

There are many different types of programs. There's gardens. There's linkages with the World Food Program. And we are linking more and more with the other parts of

the U.S. government who do more on food.

KOLBE (?):

So you're linking with other programs that may be U.S. government, Global Fund...

(CROSSTALK)

KOLBE (?):

... WFP, but these are not PEPFAR funds?

DYBUL:

We also fund a small amount of nutritional support that is medically indicated. And people do things like write prescriptions for people who medically require the food and there's a system set up, for example, in Kenya that does this.

So we do, in fact, support some food for medical purposes. And we also support food support for orphans and vulnerable children.

KOLBE (?):

Thank you.

Ms. Lowey?

LOWEY:

Thank you.

And I hope you advocate just as strongly for the family planning programs in the FY '07 budget.

I'm quite impressed with the PMTCT program results, but I'm concerned because it is my understanding that some of the organizations implementing those programs are not incorporating family planning into the counseling provided to women upon giving birth. And given that up to 35 percent of the women in PEPFAR countries say they have an unmet need for contraception, I believe we're losing an opportunity here to prevent unintended pregnancies and potential future infections.

Could you tell me what OGAC could do or will do or are doing to ensure that these women receive full information, as well as access to contraceptives if they so desire?

DYBUL:

Thank you for those comments on PMTCT.

Overall, I think we can do better and need to do a little bit better. And really where we're trying to move is away from single dose or short-course therapy to full therapy, which can be far more effective than the short course as capacity is being built.

And the PMTCT is one of our very important focus, both because of the women and also because of the kids. It's more of a family-based approach than just a simple one-drug intervention.

We are, as I mentioned, for example, having announcements come out that are direct dual funding -- family planning dollars and HIV/AIDS dollars -- so that we do have such linkages. I mentioned Kenya's because it's fairly recent, but there are a

number of others that do this.

We also have more direct linkages from care and treatment sites and counseling and testing sites to family planning sites, and this is all encouraged in our guidance.

I am certain we can be doing better at everything.

We are trying to work within the confines of limited capacity and trying to strengthen and push these things forward, but it is a formal part of guidance that we give that there should be such linkages between family planning and HIV/AIDS activities.

LOWEY:

I appreciate that.

Because I understand that there's been some confusion surrounding some of the wrap-around family planning and AIDS programs, particularly with respect to whether recipients of AIDS funds need to certify compliance with the Mexico City policy. And there is concern that some groups may shy away from applying for AIDS funds just because they know they cannot receive family planning funds.

And I understand that OGAC and USAID have been urged to send a cable to the country teams clarifying this policy for potential grantees. Could you tell me if there are plans to send such a cable?

DYBUL:

I don't recall if a cable has gone, but we have something called "notes to the field," which is how our office communicates with the field, and there have been several correspondence on this. And, again, a letter was just sent as a request, and that's going to be widely available.

I don't know if we've gone to a cable yet. We could use one. But to be honest, the notes to the field have actually been more effective because they are much more widely distributed. I still don't read cables, and I'm in the State Department.

But people in the field are not used to always reading cables, so that's why we've developed this notes to the field system, and such communication has gone, I believe on two or three occurrences, but if it would be preferable and if people would prefer a cable, it would not be difficult to take what's already been sent and put it into a cable.

LOWEY:

As long as the notification...

(CROSSTALK)

LOWEY:

That's what's important.

Regarding microbicides, it's increasingly clear that being female, married and poor are often the most significant risk factors for acquiring HIV infection, especially in sub-Saharan Africa. The feminization of the epidemic calls for research into new prevention technologies that women can initiate, such as microbicides.

And the U.S. government has played a key role in developing microbicides and supporting clinical trials, but PEPFAR has generally stayed out of the microbicides business, declaring microbicides as falling outside its mandate.

Do you view this exciting emerging prevention technology as falling outside the OGAC's purview? And if so, what is OGAC doing to support women-initiated prevention methods?

DYBUL:

Thank you. I think it's a very important question. Coming from NIH and being a scientist, I appreciate it greatly.

In the total PEPFAR funding, microbicides actually is included. Included in research in that total topline number are our international efforts on vaccines and microbicides, and we will not achieve the goal of an AIDS regeneration without a vaccine or microbicides.

Our implementation piece of it, what we send to you in our congressional notifications, does not engage in research. It actually applies research.

So as a microbicide -- and as you know, there are some very hopeful compounds out there -- as they become available and are incorporated into normative guidance, it would then be the role of our implantation arm to utilize them. And we have every intention of doing so as they become available, to move them right into our implementation arm.

LOWEY:

Thank you. I guess that's it.

KOLBE:

Thank you. We're a little bit out of sequence, but we'll go to Mr. Fattah next here.

FATTAH:

Thank you, Mr. Chairman.

I got a chance to ask a brief question in the first round. So let me get back at this. Let's start with the overall. (inaudible) total number of AIDS case worldwide, your estimate at this time is what number?

DYBUL:

There are approximately 40 million HIV-infected persons in the world. There's a range. It's somewhere between 38 million and 40 million.

FATTAH:

About 25 million or so you believe are in sub-Saharan Africa...

(CROSSTALK)

DYBUL:

Twenty-seven million, 25 million, somewhere in that neighborhood.

FATTAH:

There's a large population of AIDS cases in India, too. What's your estimate for India?

DYBUL:

The estimate in India currently is approximately 5 million people with HIV/AIDS. That's not AIDS...

(CROSSTALK)

FATTAH:

In India, what's your sense of the percentage of those who have gotten it through blood transfusions from tainted blood supplies?

DYBUL:

The estimates from India on transmission through blood are much higher than Africa. Much of that seems to be unsafe medical injections...

FATTAH:

I'm not asking about a comparative to Africa, I'm asking what is the percentage of the India cases that you believe are due to a tainted blood supply.

DYBUL:

I actually haven't seen the tainted blood supply. I've seen more a combination of blood supply and needles. There's a great deal of unsafe medical injection in India using needles that are intended for single use multiple times.

And I haven't seen some recent numbers, but, for example, the difference in these medical modes of transmission in Africa, which are a couple of percentage points, could be five- to tenfold higher in a place like India.

FATTAH:

So estimates that have been around that there are about 2 million pediatric AIDS cases in Africa related to blood transfusion. Is your judgment on that, especially given the report that you're getting ready to issue, is what?

DYBUL:

Well, I would have to look, I haven't seen the final report myself, so I don't know the number of the 27 million that are estimated to be from blood transfusion, but because blood transfusion and medical injection themselves are only a couple percentage points of the 27 million, 2 million might be high. But I would have to look at it. I don't know the numbers off the top of my head.

FATTAH:

OK. Now, have you been yourself involved in this collaborative effort between the World Health Organization, the CDC and others who are working with your office to produce the plan that the committee is waiting on?

DYBUL:

I have not seen it yet. As the chief medical officer, as it becomes final, I will see it. But we have people in our office -- my expertise as a physician and scientist is therapeutics, HIV treatment, so I am not engaged in the technical discussions around...

(CROSSTALK)

FATTAH:

... this is on the prevention side. It's a question about whether or not cleaning up the blood supply would prevent large numbers of people from getting HIV. And as you heard from -- Congressman Kirk was asking you earlier about the cost on the treatment side. Obviously, prevention is a very important issue. If there's an opportunity to treat and prevent large numbers of cases, that's the point of the report that we're interested in seeing.

DYBUL:

Right.

FATTAH:

And I do think it might be an approach that falls outside of the ABC approach, but that could result in significant reductions in actual cases that did have this long-term treatment cost associated with them.

DYBUL:

Well, I was more responding to whether or not I personally, as a technical person, have engaged in the technical discussions to this point on the blood report. I have not. We have technical experts who have. It will come to me before it comes to the full committee.

As I mentioned, we do, in fact, have many programs in terms of medical transmission of HIV. There is the sexual transmission, which we deal with heavily and many resources for, but about a half of our resources go for medical transmission, including safe blood programs, safe medical injection programs, and prevention of mother...

FATTAH:

Is that because you believe that half the transmission are medical transmissions?

DYBUL:

No, absolutely not. In fact, a very small percent in Africa are due to medical transmission, a very small percent. The vast majority, well over 90 percent, are sexual transmission.

The reason is, the cost per person is so much higher for medical interventions than it is for prevention education programs, and so it's really a cost per person, just as treatment, even though it reaches few people, is about half of our budget. That's because it costs so much more.

So the medical prevention interventions are generally more expensive than other interventions.

FATTAH:

What is your perception of the testing of blood supplies in sub-Saharan Africa now, those 45 countries? Do you think the blood is being tested before it's being used in transfusions?

DYBUL:

It's highly variable, as I mentioned.

One important thing is, in terms of testing, if you go to a blood clinic anywhere in Africa and compare it to the general population, the percent of blood units that are infected is usually on the order of five- to tenfold lower percentage, sometimes less than that, than the general population.

The reason is, there's a non-medical screening process that occurs where they basically screen out the vast majority. So, for example, in Kenya, where 10 percent or 7 percent of the population is infected, in the blood supply it's only 2 percent.

So there's the non-medical piece and then there's the medical piece.

Some countries have done an extraordinarily good job. South Africa has done well.

(CROSSTALK)

FATTAH:

The CRS, the Congressional Research Service told us that there would be no country in sub-Saharan Africa that you would want to get a blood transfusion. Would that be a statement that, given your expertise, we should abide by, or do you think that's a statement that's not based in fact?

DYBUL:

It is certainly not true that there is no blood transmission in Africa. There are certain countries, such as South Africa...

FATTAH:

No, a place in sub-Saharan Africa for safe blood transfusion purposes. That is, where you would be assured that you would not be getting transmitted with the blood of blood-borne illnesses?

DYBUL:

There are several countries that have developed very clean blood supplies. South Africa, Botswana. Kenya's getting there. They're ion the hundreds of thousands of safe and tested units a year, and they're really moving forward. Some countries have a ways to go, but that's why we're providing so much assistance and why we've supported 600 sites so far for safe blood and 8,000 trainings. There's certainly a ways to go.

But some countries have done a remarkably good job.

FATTAH:

OK. That's one of the questions that the committee asked. So I assume we'll see in your report in a few weeks an understanding of what the need is and where you think there is...

DYBUL:

Yes, absolutely.

FATTAH:

OK.

Thank your, Mr. Chairman.

KOLBE:

Thank you.

I have just a couple of more remaining questions then we can wrap this up.

Do you have a couple, Mrs. Lowey? I don't know, do you have another round that you'd like to go through.

FATTAH:

I'm going to sit here and be inspired by you, Mr. Chairman.

KOLBE:

I doubt that you'll get that much inspiration. But anyhow. And we will come back to you if you do.

Let me just very quickly. I wanted to ask about the New Partners Initiative. The president announced this thing in December, this idea, which would be $200 million in grants, I believe, for new partners to provide HIV/AIDS prevention and care services in the focus countries.

Tell me, what is the purpose of the initiative and how much do you estimate you're going to spend in fiscal year 2006 and how much are you projecting in the budget in 2007?

DYBUL:

The purpose of the New Partners Initiative, to some degree, gets to one of the parts of Mrs. Lowey's statement, which is we need to push activities into the rural areas. We need to get to the local community levels. And to do that, we're going to need some new partners who have the ability to get to the countries, to the get to the rural areas, to get outside and to push as far as possible.

And it really gets to the need for new people, who are doing very good work in many of the countries often, or affiliated with groups that are doing good work in the countries, but are not familiar with U.S. government granting processes.

And as I'm sure everyone knows, these are not easy things to do. Just learning how to apply for a government grant is a very cumbersome and difficult thing.

And so what we're trying to do is get as many people engaged and available to promote prevention, care and treatment, to have the scale-up that's necessary, so that we can achieve the goal.

So it's really to bring in more partners that are experienced and do good work, but either haven't added AIDS on to what they do -- for example, there are networks of clinics throughout Africa that don't formally do HIV/AIDS work because they don't know how to test and don't have any technical assistants to reach those groups, and also to reach other groups that have AIDS expertise, but haven't received money from the U.S. government.

KOLBE:

But a lot of the partners that we've talked to, either in my travels in Africa or here in Washington, have said that they really have the ability to scale-up their services and provide additional prevention and treatment services in the focus countries. I was just a little curious as to why we're looking to bring in new partners. Aren't we just duplicating things, adding to the overhead?

DYBUL:

Well, a couple things on that.

First, I wouldn't be overly surprised for a partner to say they can do everything, because they would then get the money to do that. And we think we need a broader partner base than the partners we currently have to actually reach everyone, because we do need this massive scale-up.

In terms of overheads, we actually think there's a good possibility that we can reduce overheads.

One of the things we're trying to encourage is what's called umbrella grants. An umbrella grant is an organization that will manage kind of the intensive parts of a U.S. government grant -- the budget, the financial management -- so that the groups themselves aren't encumbered by that, so that all these great groups that are doing fantastic work out at the community level pay a very small percent, generally in the single digits, of what would be called overhead or administrative costs, so that most of the money could then be utilized to provide services.

KOLBE:

You didn't get a chance to answer my initial question, which is, how much do you expect to spend in 2006 and what's your projection in 2007 budget?

DYBUL:

I believe between '05 and '06, it's approximately $75 million, and then $65 million in '07. But I'd have to check those numbers for you.

KOLBE:

OK.

Last question. You've talked a bit about the 2-7-10 goals in the 15 focus countries, the $15 billion over five years dedicated to reaching them, and I think we're fairly satisfied we're on track with that. (inaudible) it's not quite so clear the priorities and goals that we have in the non-focus countries, which you're still also responsible for, because you have the responsibility for the funding, oversight of the funding in the other agencies there, especially considering the fact that some of these non-focus countries suffer from even higher HIV/AIDS prevalence rates than in the focus countries.

How are you strategically allocating resources and measuring the impact of those resources in non-focus countries.

DYBUL:

It's an excellent question, and it gets back to multiple discussions we've had so far, which is, what is the U.S. government's role in this epidemic and the purpose of focus countries fundamentally.

And it really was to say, national scale-up is remarkably different from pilot projects. And rather than spread $15 billion over 120 countries, one of the expertise of the U.S. government is its expertise and supporting nations for national scale-up, to show what it takes for national scale-up for prevention, care and treatment, these systems, supply-chain management, logistics, financial management that you need for national scale-up, as opposed to pilot projects that you could spread all over that could be very effective but will never get us to global reach.

And so that's the purpose of the focus countries, and that's why the goals are targeted to the focus countries, so that we could get to 2-7-10 in 15 countries and demonstrate how it be done and that to use those lessons across the globe.

And that's what we see our activities in the other countries to be doing, to support (OFF-MIKE) one of our clearest guidance is that all of the other countries should be really thinking about how we best support Global Fund grants in those countries, because the rest of the world needs to respond in the way the American people have responded so that we have a global response.

And so the vision is to support those programs, particularly technical assistance, particularly in countries such as China, Russia and India that have their own resources, to provide a technical exchange to help them grow and to support the Global Fund in many other countries, and actually in those countries as well.

And in terms of monitoring and evaluation, we are bringing the countries in line to report in a similar way to the way the focus countries report, not in as much detail, because they don't have the resources.

We're also bringing them in line in terms of strategic vision and operations plan to see how they are, in fact, doing those things.

KOLBE:

How much of this is being done by USAID and how much by CDC?

DYBUL:

I believe in terms of budget, about two-thirds is USAID and about a third is HHS.

KOLBE:

And do you help coordinate the strategies for allocating those resources, I mean, say, within the USAID money, say, "We need more of a program over here in Russia, it's a non-focus country, we need (inaudible) more of the resources there"?

DYBUL:

Yes. As a matter of fact, we do. As everything we do, there's an interagency process where we have a deputy principals group that meets to bring the opinions of their agencies together. We also meet with parts of the State Department that have resources through other parts of this committee's efforts and others for HIV/AIDS. And then those recommendations go to a policy group, which is also interagency, of the principals for HIV/AIDS in the different departments.

So it's a very much interagency approach.

The two-thirds, one-third, by the way, is overall. I would have to look to see what the distribution is within the other bilateral programs.

KOLBE:

Thank you.

Mrs. Lowey?

LOWEY:

I wanted to ask a question on gender-based violence, but first of all I wanted to thank the chairman for bringing up the New Partners Initiative, because one of my concerns is that similar work has been under way for sometime, funded by USAID through programs like the CORE Initiative and Community Reach. And while NPI has been scaled-up, these programs have been cut back.

And we know that the goal of groups like CARE and a whole range of other groups has been to build local capacity, work with locals to train them.

So at some point -- not know -- I'd like to get more information about the NPI, because if we're going to just create new groups and not build on local capacity and the training by groups that have been so successful in these communities, these countries for a long time, I think it is questionable. But I'd like to have a further discussion with you on that.

ABC strategies rest on the underlying assumption that people are in control of their destinies. And I often think that ABC interventions forget that there are huge numbers of people, particularly young women, who really don't have a choice, whether through rape, sexual coercion, abuse, cultural and family pressures, husbands who cheat, or a response to poverty.

If you can discuss with me how OGAC is addressing the serious shortcomings that exist in the ABC approach for people whose sexual activity is more or less out of their hands. How are you addressing gender-based violence?

DYBUL:

I think it's an excellent, excellent question, and something we discuss I think fairly extensively in the annual report and everything we publish, because gender is a driver of AIDS and gender inequality is a driver of AIDS.

And I can address it on a couple levels. One is kind of on a policy level -- cultural level. There are cultural norms and activities that promote inequality between women.

I can give you just one example coming back from Zimbabwe, where we've been very active in the cultural area. I can give you some substance behind that.

There is a church in Zimbabwe which covers 8 percent of the population that encouraged polygamy, multiple wives. And this year -- and I have largely because of a lot of work from the United States government to work with an interfaith organization and group -- the church has formally reversed itself and says polygamy should not occur, that because of HIV/AIDS you need to have one wife, and she needs to be tested, and the husband needs to be tested.

And so there are these cultural shifts that need to take place, and in fact are taking place, but they've taken quite a bit of time.

Overall, we have about 350 activities in the operations plans you are looking at to address male norms and behaviors. (inaudible) numbers, but I'm trying to give you a sense of how important they are to us, because of the numbers of activities; 105 activities promoting increased legal protection for women.

So these are things we're trying to address but are very difficult.

Transgenerational sex is a major issue, and there are many programs to look at transgenerational sex.

Stigma is a bad thing in general, but it's not bad to stigmatize the older men who have sex with younger women and stigmatize that type of transgenerational sex.

And we're working on those types of approaches as well.

I think gender-based violence is a very, very important topic. I personally have visited many of the sites where you see these absolute tragedies.

Getting back to integrating programs, the president, prior to the G-8 last year, announced that a gender violence, women's violence program, and it's actually based in South Africa. And I visited those sites.

Since that announcement, we are now co-funding some of these sites with HIV/AIDS money, and with the president's money for the gender-based violence initiative, because they are related, and we can work together to fund some of these activities.

But it's going to take an awful lot of work, and there's a lot to do to try to change the way things are done. And we're working so hard to do it.

I think an important piece, though, is make sure the services are available, too, which is why we are so excited that 60 percent of the treatment where we can report it are women, 69 percent of the counseling and testing is women.

But that's not going to solve it. It's not just provision of services, it's dealing with these underlying issues. And we're trying very hard to do it.

I would have to say that we don't know the best programmatic interventions to achieve these goals, and that's why this year we're having a consultation, I think in three weeks or four weeks, with a number of groups that are interested in this to talk about what, in this year, what programmatic intervention should we do to try to address these issues and do a target evaluation to see what the most effective ones are so that we can move that forward.

Because we need to learn the most effective ways, so that we can implement them. Just like in microbicide, you need to learn what's the most effective (inaudible) and then you implement. And we're trying to work on all of that.

It's a long, long road, but I have to tell you, I'm incredibly excited about the progress that's been made so far. We have a lot more to do, but it's something we're very focused on and we need to be focused on, because we won't solve this epidemic if we don't.

LOWEY:

I just want to briefly say, since my sand is running out over here, that for me this hearing has been tremendously worthwhile, and your enthusiasm, your knowledge, your commitment really does make a difference. And I know that the chairman and I and the entire committee will look forward to working with you.

I think of our -- on this particular issue -- think of our visit to the Masai village in Arusha, USAID -- I don't know if you've been there.

DYBUL:

Yes, I have.

LOWEY:

But that woman who ran away three times, then finally she got her education in Dar es Salaam, came back to the community. And it's tough. It's making a difference. You still see the chief's hut and all the little huts around it, and HIV/AIDS is alive and well and strong. But you just have the feeling that if we work with her and we can commit to more programs like this, we can make a difference.

So with your leadership, I know this partnership will be effective. And I thank you very much.

KOLBE:

Thank you, Mrs. Lowey.

Mr. Fattah, do you have another question?

FATTAH:

I don't think I'm going to ask a question, Mr. Chairman. I'm just going to say that I share the chairman's interest and concern about this New Partners Initiative. And as part of a larger context, which is that our rhetoric seems to be that, well, we're interested in having nationwide solutions and building government-level support for long-lasting approaches to AIDS prevention and treatment, and in particular sub-Saharan Africa, but we seem to put a lot of our money into NGOs.

So that if you trying to get the health department in one of these countries, they have limited communications capabilities, limited capacity, and the NGOs have all the capacity, which I think that we're going to have to think about creating some infrastructure at the governmental level in these health ministries.

Now, I know you've done some work on this, but I think we need to be thinking about as we go forward creating an institutional capacity at the governmental level to work on these problems and not just looking at NGOs as a method, because it's really kind of a fleeting thing, where what we need to be doing is creating a long term infrastructure.

Thank you, Mr. Chairman.

KOLBE:

Thank you very much.

And I would echo the words of Mrs. Lowey in saying we really appreciate your outstanding testimony today. You've certainly more than lived up to the reputation, which I knew you would, of being an extraordinarily qualified individual.

I've always been impressed with your ability, and certainly today you more than measured up to that, and we thank you very much for your testimony and the answers that you gave us.

I think you've helped us to understanding some of these programs a lot better, and that helps us make better policy as we go forward.

Thank you.

The subcommittee stands adjourned.

CQ Transcriptions, March 9, 2006

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